

Centers for Medicare & Medicaid Services, HHS

§416.2

- 416.172 Adjustments to national payment rates
- 416.173 Publication of revised payment methodologies and payment rates
- 416.178 Limitations on administrative and judicial review
- 416.179 Payment and coinsurance reduction for devices replaced without cost or when full or partial credit is received.

Subpart G—Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Service Centers

- 416.180 Basis and scope.
- 416.185 Process for establishing a new class of new technology IOLs.
- 416.190 Request for review of payment amount.
- 416.195 Determination of membership in new classes of new technology IOLs.
- 416.200 Payment adjustment.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 47 FR 34094, Aug. 5, 1982, unless otherwise noted.

Subpart A—General Provisions and Definitions

§416.1 Basis and scope.

(a) *Statutory basis.* (1) Section 1832(a)(2)(F)(i) of the Act provides for Medicare Part B coverage of facility services furnished in connection with surgical procedures specified by the Secretary under section 1833(i)(1) of the Act.

(2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center.

(3) Sections 1833(i)(2)(A) and (D) and 1833(a)(1)(G) of the Act specify the amounts to be paid for facility services furnished in connection with the specified surgical procedures when they are performed in an ASC.

(4) Section 1833(i)(2)(C) of the Act provides that if the Secretary has not updated amounts for ASC facility services furnished during a fiscal year through 2005 or a calendar year beginning with 2006, the amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved,

except that, in fiscal year 2005, the last quarter of calendar year 2005, and each of the calendar years 2006 through 2009, the increase shall be zero percent.

(5) Section 1833(i)(2)(E) of the Act provides that, with respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system, the payment amount shall be the lesser of the ASC payment rate established under section 1833(i)(2)(A) of the Act or the prospective payment rate for hospital outpatient department services established under section 1833(t)(3)(D) of the Act. The lesser payment amount shall be determined prior to application of any geographic adjustment.

(b) *Scope.* This part sets forth—

(1) The conditions that an ASC must meet in order to participate in the Medicare program;

(2) The scope of covered services; and

(3) The conditions for Medicare payment for facility services.

[56 FR 8843, Mar. 1, 1991; 56 FR 23022, May 20, 1991, as amended at 71 FR 68226, Nov. 24, 2006]

§416.2 Definitions.

As used in this part:

Ambulatory surgical center or *ASC* means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part.

ASC services means, for the period before January 1, 2008, facility services that are furnished in an ASC, and beginning January 1, 2008, means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures.

Covered ancillary services means items and services that are integral to a covered surgical procedure performed in an ASC as provided in §416.164(b), for which payment may be made under §416.171 in addition to the payment for the facility services.